

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4267

CERTIFICATE OF DEATH

04257
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Alton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicans Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle COLE Last ARMSWORTHY		4. DATE OF DEATH Month April Day 26 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 1, 1934
9. AGE (In years last birthday) yrs. 75		IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min. 0 IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman Retired		10b. KIND OF BUSINESS OR INDUSTRY State Roads	
11. BIRTHPLACE (State or foreign country) St. Mary's County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James H. Armsworthy		14. MOTHER'S MAIDEN NAME Catherine Cullison	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-12-1880	
17. INFORMANT Mrs. Emma T. Armsworthy - Bel Alton, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Heart Failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Myocardial Infarction (c) Arteriosclerotic Hypertensive Heart Disease - years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obesity		INTERVAL BETWEEN ONSET AND DEATH 30 min. 22 hours	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) no accident	
20c. TIME OF INJURY Month, Day, Year 5:00 p.m. 4-25-59		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Gaulhner, Charles, Md		20f. (City or town) (County) (State) La Plata, Maryland	
21. I certify that I attended the deceased from 4-24, 1959 to 4-26, 1959 , that I last saw the deceased alive on 4-26, 1959 , and that death occurred at 2:45 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE V.B. Dettor		DATE SIGNED April 27, 1959	
PHYSICIAN'S NAME (Type) V.B. Dettor		M.D. La Plata, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/29/1959	
22c. NAME OF CEMETERY OR CREMATORY St. Ignatius Church Cem.		22d. LOCATION (City, town, or county) (State) Bel Alton, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE AREHART FUNERAL HOME, INC. * LA PLATA MD.		24a. REC'D BY REGISTRAR May 5 '59	
24b. REGISTRAR'S SIGNATURE Cullison & House			

CERTIFICATE OF DEATH

5283

WEST VIRGINIA STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

<p>1. Name of deceased: <u>John Doe</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>Jan 1, 1900</u></p>		<p>4. Place of birth: <u>West Virginia</u></p>	
<p>5. Date of death: <u>Dec 1, 1950</u></p>		<p>6. Place of death: <u>Home</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Manner of death: <u>Natural</u></p>	
<p>9. Signature of physician: <u>Dr. J. Smith</u></p>		<p>10. Signature of registrar: <u>J. Doe</u></p>	
<p>11. Signature of informant: <u>John Doe</u></p>		<p>12. Signature of witness: <u>John Doe</u></p>	
<p>13. Signature of registrar: <u>J. Doe</u></p>		<p>14. Signature of registrar: <u>J. Doe</u></p>	
<p>15. Signature of registrar: <u>J. Doe</u></p>		<p>16. Signature of registrar: <u>J. Doe</u></p>	
<p>17. Signature of registrar: <u>J. Doe</u></p>		<p>18. Signature of registrar: <u>J. Doe</u></p>	
<p>19. Signature of registrar: <u>J. Doe</u></p>		<p>20. Signature of registrar: <u>J. Doe</u></p>	
<p>21. Signature of registrar: <u>J. Doe</u></p>		<p>22. Signature of registrar: <u>J. Doe</u></p>	
<p>23. Signature of registrar: <u>J. Doe</u></p>		<p>24. Signature of registrar: <u>J. Doe</u></p>	
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<p>83. Signature of registrar: <u>J. Doe</u></p>		<p>84. Signature of registrar: <u>J. Doe</u></p>	
<p>85. Signature of registrar: <u>J. Doe</u></p>		<p>86. Signature of registrar: <u>J. Doe</u></p>	
<p>87. Signature of registrar: <u>J. Doe</u></p>		<p>88. Signature of registrar: <u>J. Doe</u></p>	
<p>89. Signature of registrar: <u>J. Doe</u></p>		<p>90. Signature of registrar: <u>J. Doe</u></p>	
<p>91. Signature of registrar: <u>J. Doe</u></p>		<p>92. Signature of registrar: <u>J. Doe</u></p>	
<p>93. Signature of registrar: <u>J. Doe</u></p>		<p>94. Signature of registrar: <u>J. Doe</u></p>	
<p>95. Signature of registrar: <u>J. Doe</u></p>		<p>96. Signature of registrar: <u>J. Doe</u></p>	
<p>97. Signature of registrar: <u>J. Doe</u></p>		<p>98. Signature of registrar: <u>J. Doe</u></p>	
<p>99. Signature of registrar: <u>J. Doe</u></p>		<p>100. Signature of registrar: <u>J. Doe</u></p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4268

CERTIFICATE OF DEATH

04258

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CHARLES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland.</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LA PLATA</u>		c. LENGTH OF STAY IN TB <u>1 day.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Physicians Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ATKINSON, Mary Catherine</u>		4. DATE OF DEATH <u>April 29 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8 Jan 57</u>
9. AGE (In years last birthday) <u>2</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Never worked</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Richard S. ATKINSON</u>		14. MOTHER'S MAIDEN NAME <u>Mariatta Freeman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Richard S. ATKINSON.</u> Address <u>Indian Head.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory collapse.</u> <u>493X</u> DUE TO <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>28 April, 1959</u> , to <u>29 April, 1959</u> , that I last saw the deceased alive on <u>29 April, 1959</u> , and that death occurred at <u>1:55 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Arthur O. Woody</u>		ADDRESS (Street, city or town, state) <u>La Plata, Md.</u> DATE SIGNED <u>29 April 59</u>	
PHYSICIAN'S NAME (Type) <u>ARTHUR O. WOODY</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>5/2/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bates Methodist</u>	22d. LOCATION (City, town, or county) (State) <u>Snow Hill Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard S. La Plata</u> ADDRESS		24a. REC'D BY REGISTRAR <u>—</u> DATE <u>MAY 5 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4263 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04259

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>	c. LENGTH OF STAY IN 1b <u>UNK</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Waldorf</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Physicians Memorial</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>CHARLES E</u> First Middle <u>Beaver</u> Last		DATE OF DEATH Month <u>4</u> Day <u>30</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-20-91</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>30</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bread Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bakery</u>	
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Beaver</u>		14. MOTHER'S MAIDEN NAME <u>Amelia McCavick</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WWI</u>		16. SOCIAL SECURITY NO. <u>343-09-6983</u>	
17. INFORMANT <u>Elizabeth Beaver, Waldorf, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>4-30-59</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>4-30-59</u> p. m.		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. J. EDELLEN</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. J. EDELLEN</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>5-3-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>West End Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Wytheville, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home, Waldorf, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 5 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>	

MEDICAL CERTIFICATION

2

NOT STAMP
HOSPITAL

STATE AND STATE DEPARTMENT OF HEALTH - MINNAPOLIS, MINN.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: *John J. Smith*

2. Age: *45*

3. Sex: *Male*

4. Race: *White*

5. Date of Death: *Jan 15, 1924*

6. Place of Death: *Home*

7. Cause of Death: *Myocardial Infarction*

8. Manner of Death: *Natural*

9. Signature of Examiner: *J. J. Smith*

10. Signature of Physician: *J. J. Smith*

11. Signature of Coroner: *J. J. Smith*

12. Signature of Medical Officer: *J. J. Smith*

13. Signature of Health Officer: *J. J. Smith*

14. Signature of Registrar: *J. J. Smith*

15. Signature of Clerk: *J. J. Smith*

16. Signature of Nurse: *J. J. Smith*

17. Signature of Undertaker: *J. J. Smith*

18. Signature of Burial Officer: *J. J. Smith*

19. Signature of Cemetery: *J. J. Smith*

20. Signature of Funeral Home: *J. J. Smith*

21. Signature of Mortician: *J. J. Smith*

22. Signature of Embalmer: *J. J. Smith*

23. Signature of Preparator: *J. J. Smith*

24. Signature of Assistant: *J. J. Smith*

25. Signature of Apprentice: *J. J. Smith*

26. Signature of Student: *J. J. Smith*

27. Signature of Observer: *J. J. Smith*

28. Signature of Instructor: *J. J. Smith*

29. Signature of Supervisor: *J. J. Smith*

30. Signature of Director: *J. J. Smith*

31. Signature of President: *J. J. Smith*

32. Signature of Vice President: *J. J. Smith*

33. Signature of Secretary: *J. J. Smith*

34. Signature of Treasurer: *J. J. Smith*

35. Signature of Auditor: *J. J. Smith*

36. Signature of Assessor: *J. J. Smith*

37. Signature of Collector: *J. J. Smith*

38. Signature of Inspector: *J. J. Smith*

39. Signature of Agent: *J. J. Smith*

40. Signature of Representative: *J. J. Smith*

41. Signature of Delegate: *J. J. Smith*

42. Signature of Elector: *J. J. Smith*

43. Signature of Voter: *J. J. Smith*

44. Signature of Juror: *J. J. Smith*

45. Signature of Witness: *J. J. Smith*

46. Signature of Juror: *J. J. Smith*

47. Signature of Juror: *J. J. Smith*

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81. Signature of Juror: *J. J. Smith*

82. Signature of Juror: *J. J. Smith*

83. Signature of Juror: *J. J. Smith*

84. Signature of Juror: *J. J. Smith*

85. Signature of Juror: *J. J. Smith*

86. Signature of Juror: *J. J. Smith*

87. Signature of Juror: *J. J. Smith*

88. Signature of Juror: *J. J. Smith*

89. Signature of Juror: *J. J. Smith*

90. Signature of Juror: *J. J. Smith*

91. Signature of Juror: *J. J. Smith*

92. Signature of Juror: *J. J. Smith*

93. Signature of Juror: *J. J. Smith*

94. Signature of Juror: *J. J. Smith*

95. Signature of Juror: *J. J. Smith*

96. Signature of Juror: *J. J. Smith*

97. Signature of Juror: *J. J. Smith*

98. Signature of Juror: *J. J. Smith*

99. Signature of Juror: *J. J. Smith*

100. Signature of Juror: *J. J. Smith*

~~1277 MEDICAL EXAMINER'S CERTIFICATE OF DEATH~~

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bryantown</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bryantown</i>	
c. LENGTH OF STAY IN 1b <i>4 mos</i>		d. STREET ADDRESS <i>1</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>LUCY AUGUSTA FARMER</i>		DATE OF DEATH <i>4 29 1959</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov 4 1876</i>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years (birth day)) <i>82</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Self</i>	
11. BIRTHPLACE (State or foreign country) <i>Md St Marys</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>GEORGE HAWKINS</i>		14. MOTHER'S MAIDEN NAME <i>MARY JANE BUTLER</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>DOROTHY HAWKINS</i>	
17. INFORMANT <i>DOROTHY HAWKINS</i>		Address <i>Bryantown</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Sudden Rt Heart Failure</i> 782.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>F. J. E. DELEN</i>		DATE SIGNED <i>4-29-59</i>	
EXAMINER'S NAME (Type) <i>F. J. E. DELEN M.D.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>5/2/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St. Mary's</i>	22d. LOCATION (City, town, or county) (State) <i>Bryantown, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hunt Funeral Home, Haldor, Md.</i>		24a. REC'D BY REGISTRAR <i>DATE MAY 5 '59</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. K...</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

IN SENATE
January 11, 1902
REPORT
OF THE
COMMISSIONERS OF THE
LAND OFFICE
IN RESPONSE TO A
RESOLUTION PASSED
BY THE SENATE
MAY 11, 1899
RELATIVE TO THE
LANDS BELONGING TO
THE STATE

1102

ALBANY: J.B. LIPPINCOTT & CO. PRINTERS
1902

4271

CERTIFICATE OF DEATH

04261

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>MD</u> c. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write full name and give nearest town) <u>Seabrook</u>		c. CITY OR TOWN (If outside corporate limits, write full name and give nearest town) <u>Dentalville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>RURAL.</u>	
3. NAME OF DECEASED (Type or print) <u>GOLDING Betty ANNE</u>		4. DATE OF DEATH Month <u>4</u> Day <u>18</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-8-59</u>
9. AGE (In years last birthday) yrs. <u>10</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>10</u> Days <u>10</u> Hours <u>10</u> Min. <u>10</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Wm Savoy</u>		14. MOTHER'S MAIDEN NAME <u>MARY Louise Golding</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Mary L. Golding</u>		Address <u>Dentalville Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.5</u> DUE TO <u>Atelectasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Prematurity</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>4-18-59</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4-9-59</u> to <u>4-18-59</u> , that I last saw the deceased alive on <u>4-10-59</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. J. Green</u> M.D.		DATE SIGNED <u>4-18-59</u>	
PHYSICIAN'S NAME (Type) <u>LABLATA Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>4/19/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Marys</u>	22d. LOCATION (City, town, or county) (State) <u>Bayswater Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert M. Laplata Md.</u>		24. REC'D BY REGISTRAR <u>Christina S. Harris</u>	
ADDRESS <u></u>		DATE <u>APR 24 '59</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2066323XV2

CERTIFICATE OF DEATH

10-101

Form with multiple lines for text entry, including fields for name, date, and cause of death. The text is faint and mostly illegible.

10-101



CERTIFICATE OF DEATH

04262

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>La Plata</i>		c. LENGTH OF STAY IN TB <i>12 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>John Lewis HEARD</i>		4. DATE OF DEATH Month <i>4</i> Day <i>15</i> Year <i>1959</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 10, 1877</i>
9. AGE (In years last birthday) <i>81</i> yrs.		IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min.	IF UNDER 24 HRS Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Fabricer</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Michael Heard</i>		14. MOTHER'S MAIDEN NAME <i>UNK</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <i>0</i>	
17. INFORMANT <i>Helen Heard, La Plata, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Gen. Visceral Failure</i> <i>450.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Gen. Ant. Arterios</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>Chronic</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>4-15-59</i> <i>plainly</i> that I last saw the deceased alive on <i>4-15-59</i> , and that death occurred at <i>Md.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>E. J. EDELEN MD</i>		DATE SIGNED <i>LA PLATA Md. 4-15-59</i>	
PHYSICIAN'S NAME (Type) <i>E. J. EDELEN MD</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>4-18-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St Catherine</i>	22d. LOCATION (City, town, or county) (State) <i>McConchie, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>The Hunt Funeral Home, Wb Hof, Md</i>		24. REC'D BY REGISTRAR DATE <i>APR 22 '59</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be retained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

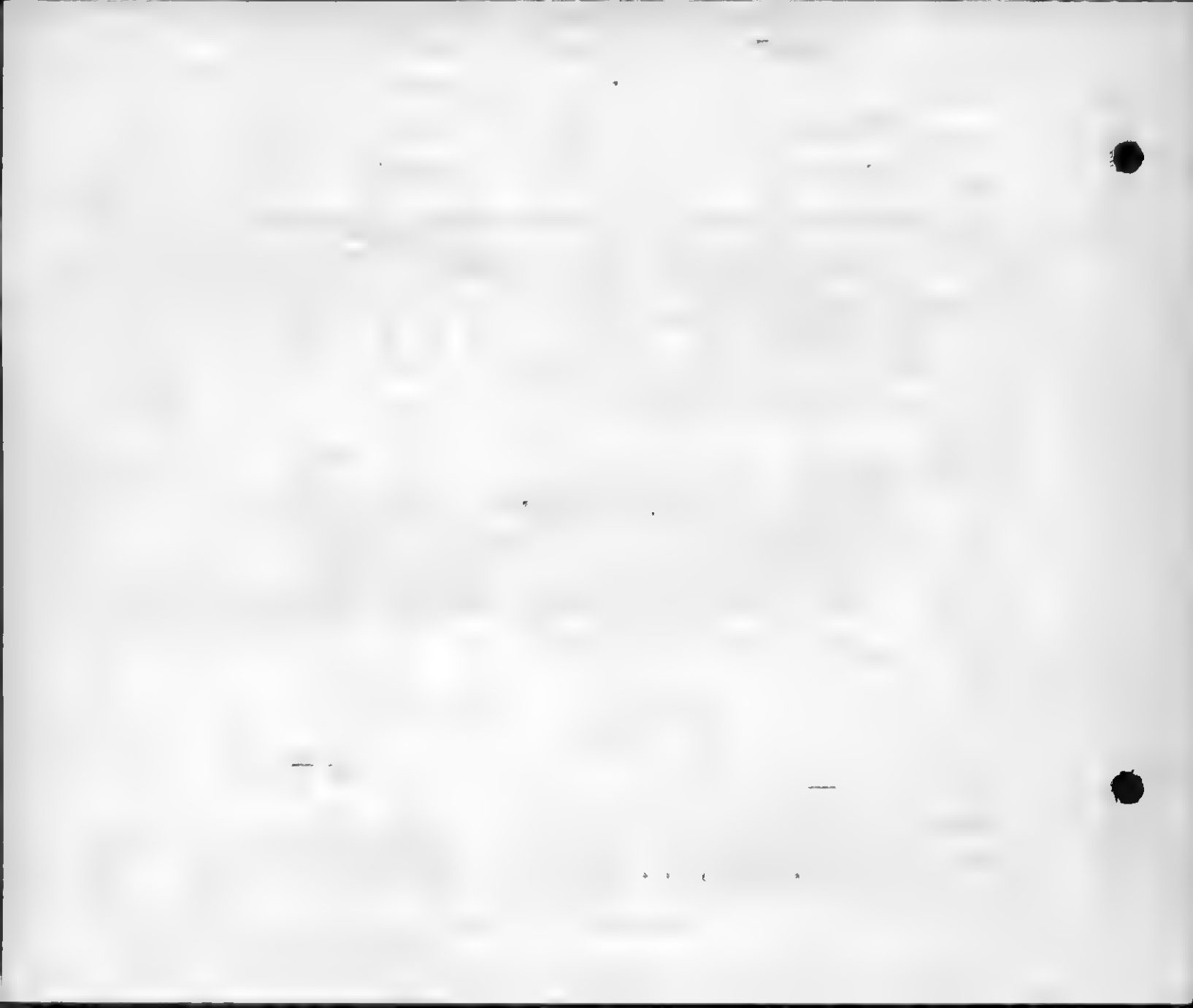
4273 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04263

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marbury c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marbury d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First RICHARD Middle GEORGE Last MADDOX				4. DATE OF DEATH Month April Day 19 Year 19 59							
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH August 29, 1958		9. AGE (in years last birthday) yrs. 8		10. IF UNDER 1 YEAR Months 8 Days 8 Hours 8 Min. 8	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child				10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Charles Co., Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Richard C. Ashto				14. MOTHER'S MAIDEN NAME Louise E. Maddox							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. No		17. INFORMANT Louise E. Maddox - Marbury, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia. 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour 19 a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.											
ACTUAL SIGNATURE Paul F. Guerin						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.						4/20/59					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 4/21/59		22c. NAME OF CEMETERY OR CREMATORY Smith's Chapel		22d. LOCATION (City, town, or county) (State) Rosebush Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Robert F. H. Inc. - La Plata, Md.						24a. REC'D BY REGISTRAR DATE APR 24 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Thane			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



4274

CERTIFICATE OF DEATH

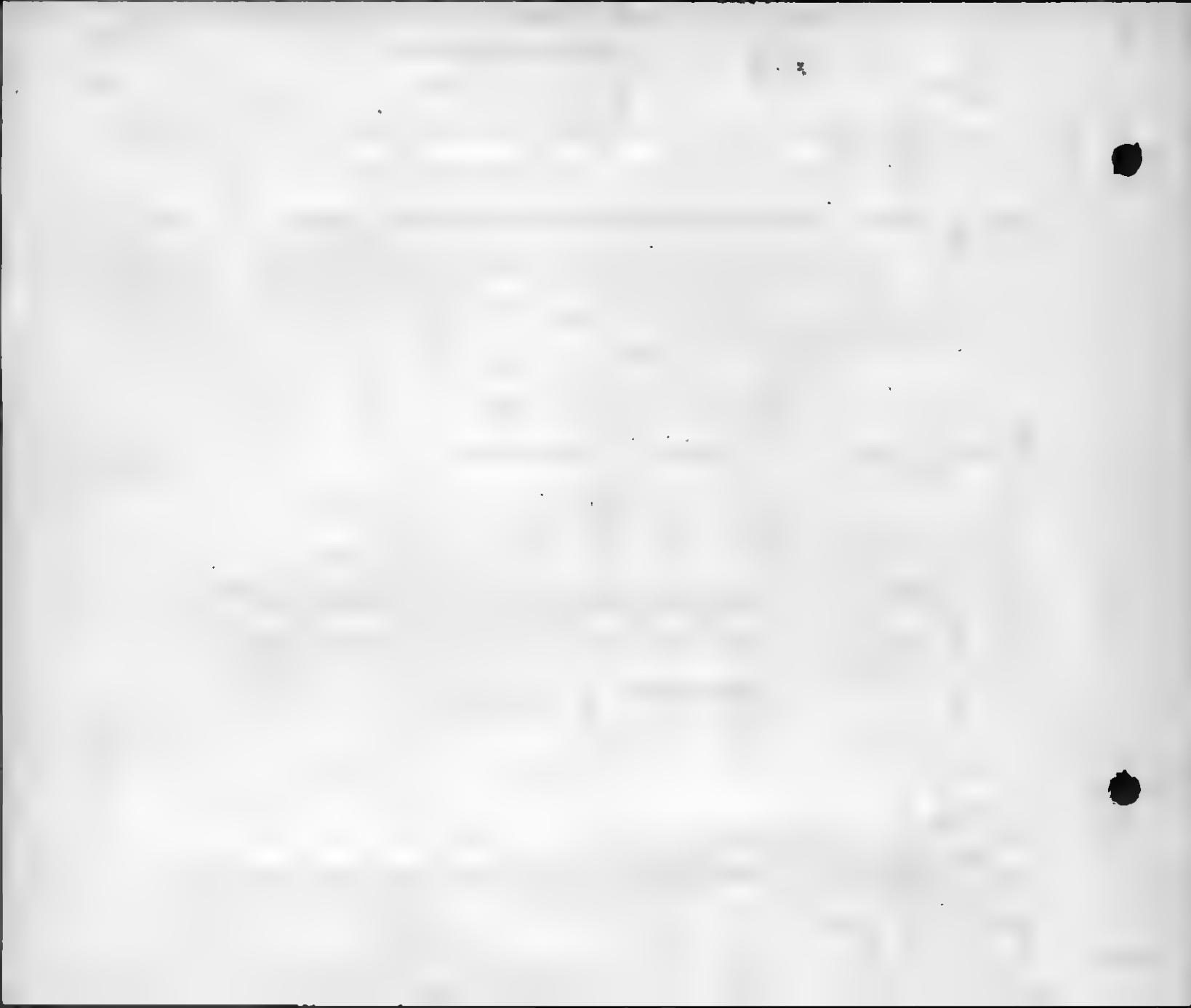
Reg. Dist. No.

04264

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MARYLAND</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>LA PLATA</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>LA PLATA</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Physicians Memorial Hospital</i>		d. STREET ADDRESS <i>(RURAL)</i>	
3. NAME OF DECEASED (Type or print) First <i>THOMAS</i> Middle <i>W.</i> Last <i>MADDOX</i>		4. DATE OF DEATH Month <i>APRIL</i> Day <i>5</i> Year <i>1959</i>	
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec, 24, 1895</i>
9. AGE (In years last birthday) <i>63</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Gov. POWDER WORKER</i>	
11. BIRTHPLACE (State or foreign country) <i>CHAS. CO. MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>JAMES FREDERICK MADDOX</i>		14. MOTHER'S MAIDEN NAME <i>JANE EMMALINE LYON</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>UNKNOWN</i>	
17. INFORMANT Address <i>Mrs. Lillian V. Posey - Washington, DC</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i> DUE TO <i>Multiple Myocardial Ischemia</i> (b) <i>Multiple Myocardial Ischemia</i> DUE TO <i>Arteriosclerotic Heart Disease</i> (c) <i>Arteriosclerotic Heart Disease</i>			INTERVAL BETWEEN ONSET AND DEATH <i>5 min.</i> <i>1 1/2 hr.</i> <i>1 year</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>No accident</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>4:30 p.m. June 19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>La Plata, Charles Co. Md.</i>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>2-23-58</i> , 1958, to <i>4-5-59</i> , 1959, that I last saw the deceased alive on <i>4-5-59</i> , 1959, and that death occurred at <i>5:20 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>V. B. Detton</i>		ADDRESS (Street, city or town, state) <i>La Plata, Md.</i> DATE SIGNED <i>4/7/59</i>	
PHYSICIAN'S NAME (Type) <i>V. B. DETTOR</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>4/8/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Rest</i>		22d. LOCATION (City, town, or county) (State) <i>LA PLATA, MARYLAND</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Chelart Funeral Home, Inc. - La Plata Md.</i>		ADDRESS	
24a. REC'D BY REGISTRAR <i>APR 10 59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanna</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



4275 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 7, 11 & 14, Film G241, 4/7/59 fcy

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>CHARLES</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAPLATA</u> c. LENGTH OF STAY in 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PHYSICIAN'S MEMORIAL HOSP.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>New York</u> b. COUNTY <u>Queens</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jamaica</u> d. STREET ADDRESS <u>189-07 Jamaica Ave.</u> <u>20280 100th STREET</u>	
3. NAME OF DECEASED (Type or print) <u>THOMAS E. MASON</u> First Middle Last		4. DATE OF DEATH <u>APRIL 3</u> 19 <u>59</u> Month Day Year	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-30-1938</u>
9. AGE (in years last birthday) <u>20</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. NAVY</u>		12. KIND OF BUSINESS OR INDUSTRY <u>MILITARY</u>	
13. BIRTHPLACE (State or foreign country) <u>New York</u>		14. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. FATHER'S NAME <u>JOHN J. MASON</u>		16. MOTHER'S MAIDEN NAME <u>Anne ?</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		18. SOCIAL SECURITY NO.	
19. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> 82° X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Internal Laceration of Chest</u> DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Auto accident - U.S. # 301</u>	
20c. TIME OF INJURY Hour <u>6:50 a.m.</u> Month, Day, Year <u>4-3-59</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>	20f. (City or town) <u>Manhasset Neck, Md.</u> (County) <u>Charles</u> (State) <u>Md.</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>J. B. Dettor</u>		DATE SIGNED <u>4-3-1959</u>	
EXAMINER'S NAME (Type) <u>J. B. DETTOR</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Shipment, 4-7-59</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>Long Island National</u>	22d. LOCATION (City, town, or county) <u>Farmingdale</u> (State) <u>New York</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Adams</u>		24a. REC'D BY REGISTRAR <u>APR 8 '59</u>	
ADDRESS <u>Adams Funeral Home, 4748 Wisc. Ave., NW, Wash. DC</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hunt</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

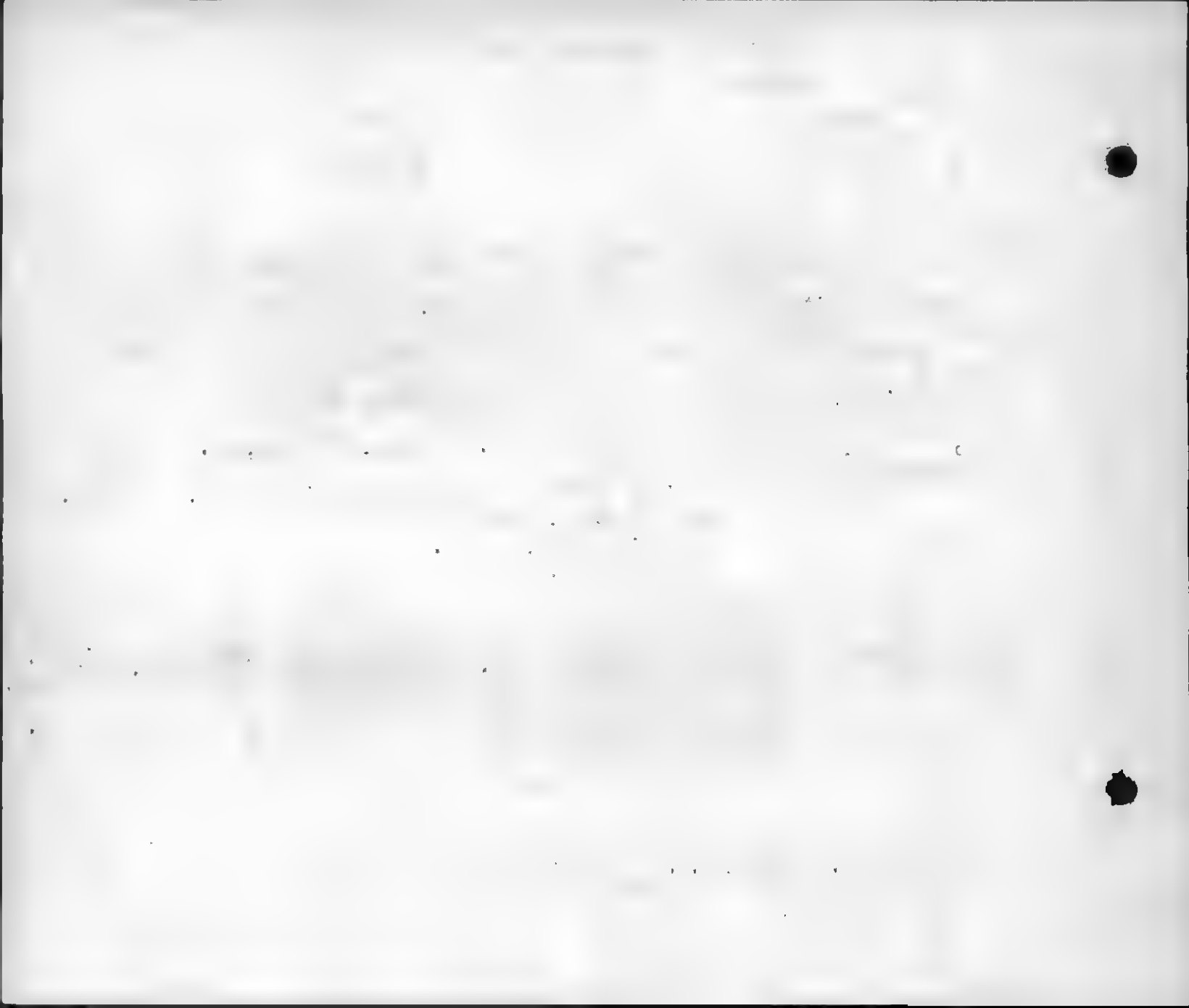
114266

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Physicians Memorial Hospital		d. STREET ADDRESS 	
3. NAME OF DECEASED (Type or print) First Theresa Middle Olivia Last McDonagh		4. DATE OF DEATH Month April Day 29 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 20, 1895
9. AGE (in years last birthday) 63 yrs		IF UNDER 1 YEAR Months 63 Days 63 Hours 63 Min 63	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY self	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Philip Reed Wills		14. MOTHER'S MAIDEN NAME Mary Louise Bowling	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 	
17. INFORMANT T. P. McDonagh, La Plata, Md.		Address 	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple fractures skull, right parietal bone, anterior fassa, right orbit. DUE TO (b) Laceration brain, 3 1/2 hrs. DUE TO (c) Multiple abrasions of arms and legs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY CAUSE OF DEATH. <input checked="" type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Vehicular collision. in northbound lane of Rt. 301 and junction of State Rt. #225 Subject thrown from car at impact striking road surface with head.			
20c. TIME OF INJURY Month, Day, Year 1:45 p m EDT 4/29 1959		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) La Plata Charles Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John H. Griffin, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) John H. Griffin, M.D. Acting		DATE SIGNED 4-30-59	
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 5/ 2/ 1959	
22c. NAME OF CEMETERY OR CREMATORY St. Ignatius Cemetery		22d. LOCATION (City, town, or county) Chapel Point, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE AREHART FUNERAL HOME, INC. *LA PLATA, MD.		24a. REC'D BY REGISTRAR MAY 5 '59	
24b. REGISTRAR'S SIGNATURE Christina L. Kline		 	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate within the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



4277

CERTIFICATE OF DEATH

04267

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAPLATA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Nantemo</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>En Route - Phys. Mem. Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>(BABY GIRL) "A." Posey</u>		4. DATE OF DEATH Month Day Year <u>APR 10 1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-10-59</u>
9. AGE (In years lost birthday) yrs <u>1</u>		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Archie Posey</u>		14. MOTHER'S MAIDEN NAME <u>MASSIE GAINOR</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Archie Posey</u>		Address <u>Nantemo, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity - D.O.A.</u> 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 10, 1959</u> , to <u>April 10, 1959</u> , that I last saw the deceased alive on <u>April 10, 1959</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank G. Susan</u> M.D.		ADDRESS (Street, city or town, state) <u>INDIAN HEAD MD</u>	
PHYSICIAN'S NAME (Type) <u>FRANK A. SUSAN MD</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4/10/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT Hope</u>	22d. LOCATION (City, town, or county) (State) <u>WELLSVILLE MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Archer + Funeral Home Inc, LAPLATA MD</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>Carling & H</u>		24b. REGISTRAR'S SIGNATURE	
DATE <u>APR 15 '59</u>			



4278

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CHARLES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CHARLES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAPLATA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X HANSENOY</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PHYSICIANS MEM. Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>(BABY BOY) "B" Posey</u>		4. DATE OF DEATH Month Day Year <u>APRIL 11 1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APR. 10, 1959</u>
9. AGE (In years last birthday) yrs. <u>6</u>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE - INFANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>ARCHIE POSEY</u>		14. MOTHER'S MAIDEN NAME <u>MASSIE GAINOR</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>Archie Posey, Jr.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 10, 1959</u> , to <u>April 11, 1959</u> , that I last saw the deceased alive on <u>April 11, 1959</u> , and that death occurred at <u>1:15 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Frank G. Susan</u> M.D. <u>INDIAN HEAD</u>			
PHYSICIAN'S NAME (Type) <u>FRANK A. SUSAN, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4/11/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT Hope</u>	22d. LOCATION (City, town, or county) (State) <u>WELCAME, MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>ARCHIE FUNERAL HOME INC, LAPLATA, MD</u>		24a. REC'D BY REGISTRAR DATE <u>APR 15 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hays</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04269

Reg. Dist. No.

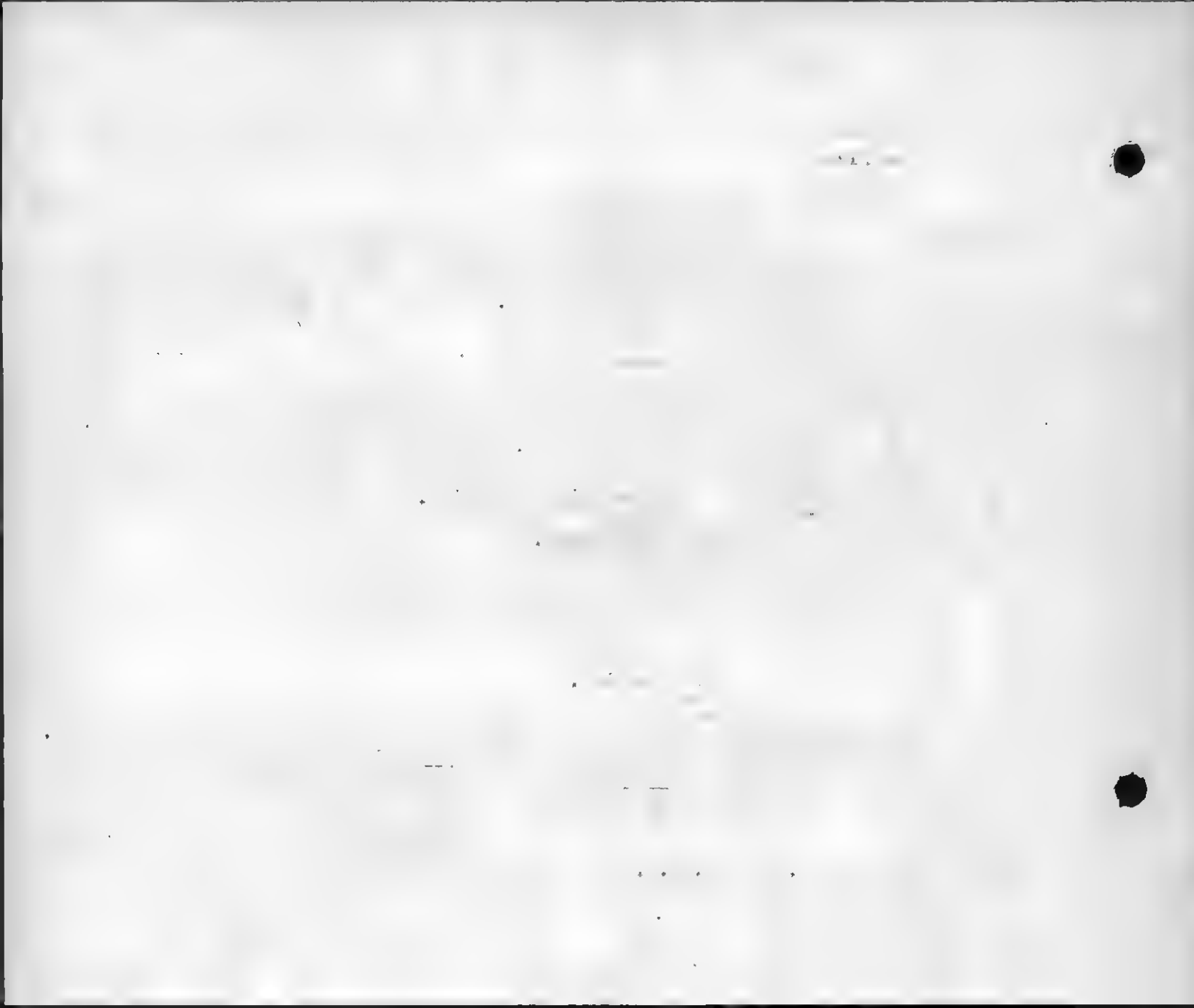
4273

Item 7 File 0241 4-27-59 et

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Physicians Memorial Hospital		e. STREET ADDRESS f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARION Middle LORETTA Last RUSSELL		4. DATE OF DEATH Month April Day 18 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Divorced	8. DATE OF BIRTH Feb. 19, 1927
9. AGE (In years last birthday) 30 3/4		10. IF UNDER 1 YEAR Months 3 Days 21	11. IF UNDER 24 HRS. Hours 3 Min. 30
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Mass.	
11. BIRTHPLACE (State or foreign country) Mass.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John D. Keith		14. MOTHER'S MAIDEN NAME Arline Thompson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 134-14-5549	
17. INFORMANT Mrs. Arline Keith		635 - Address Brooklyn Ave. Brooklyn, N.Y.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon Monoxide Poisoning. 890.0 Conditions, if any, which gave rise to immediate cause (b) Extensive Burns. (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Conflagration.	
20c. TIME OF INJURY Month, Day, Year Hour XX p. m. 4/18 19 59	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Waldorf Charles Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Paul F. Guerin		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 4/20/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/22/1959	22c. NAME OF CEMETERY OR CREMATORY Mt. Rest Cemetery	22d. LOCATION (City, town, or county) (State) La Plata, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE AREHART FUNERAL HOME, INC. * LA PLATA, MD.		24a. REC'D BY REGISTRAR DATE APR 24 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Brand

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



04270

CERTIFICATE OF DEATH

Reg. Dist. No.

4280

1. PLACE OF DEATH a. COUNTY <i>Charles</i> <i>Brayantown Md</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Char.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brayantown Md</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Brayantown Charles Co Md</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>JOSEPH DARBY SEMBLEY</i>		4. DATE OF DEATH Month Day Year <i>4 8 1959</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/28/85</i>
9. AGE (In years last birthday) <i>74</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>and</i>	
11. BIRTHPLACE (State or foreign country) <i>and</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <i>Portia Wane 121 Quincy Place N.E. Wash D.C.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CORONARY OCCLUSION</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Gen. Art Sclerosis</i> DUE TO (c) <i>CHRONIC</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4-8-59</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>1957</i> 19 <i>57</i> to <i>4-8-59</i> that I last saw the deceased alive on <i>4-3-59</i> and that death occurred at <i>2 P</i> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>E. J. Edelen</i> M.D.		DATE SIGNED <i>LA PLATA MD - 4-8-59</i>	
PHYSICIAN'S NAME (Type) <i>E. J. EDELEN M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>4/11/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St Mary cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Brayantown Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>George A. Nelson</i>		24. RECD BY REGISTRAR <i>APR 13 1959</i>	
ADDRESS <i>Aguasca Md</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



4281

CERTIFICATE OF DEATH

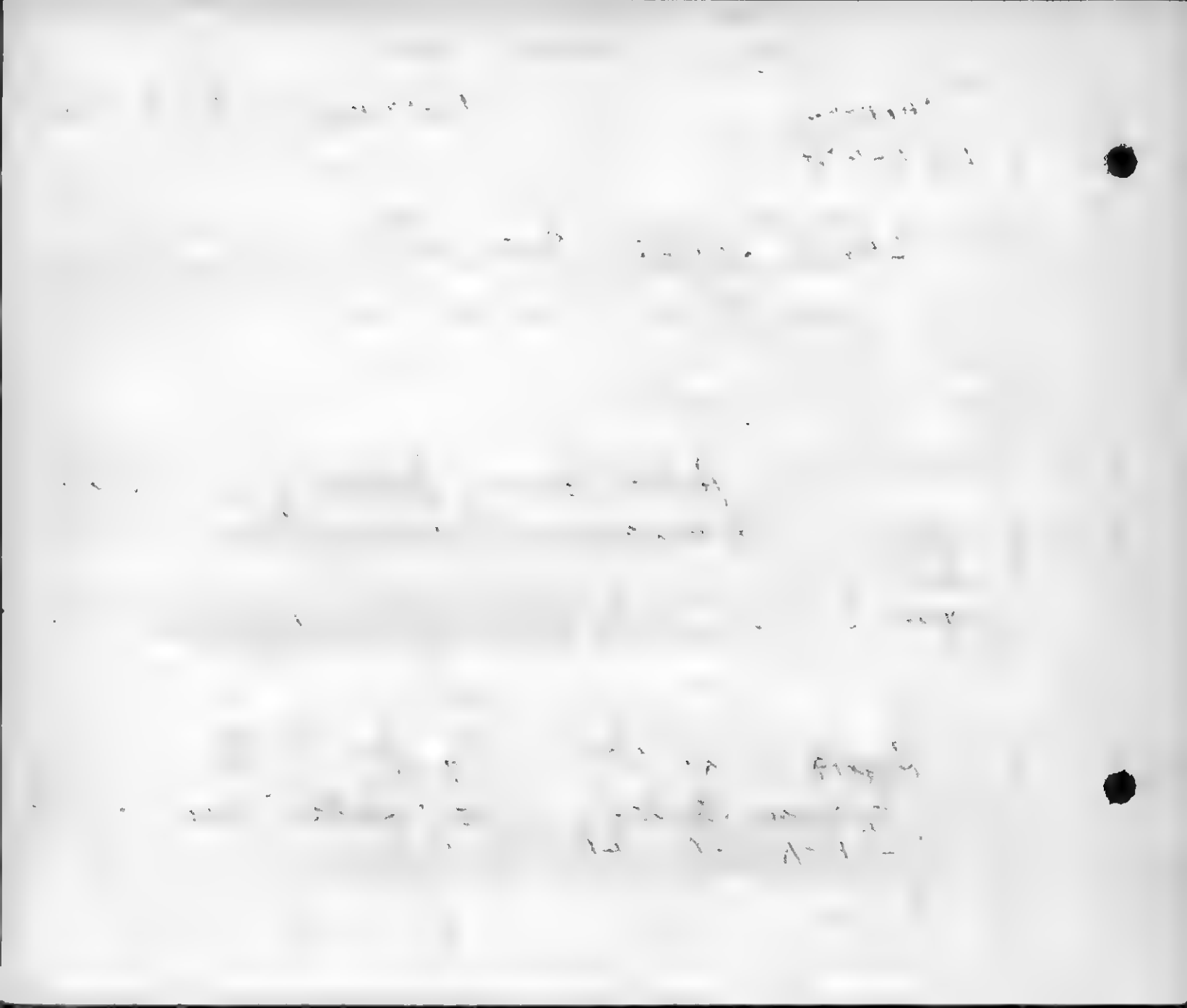
04271

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARYS	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA PLATA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Charlotte Hall	
d. NAME OF HOSPITAL (If not in hospital, give street address) Physician Memorial		d. STREET ADDRESS RURAL	
3. NAME OF DECEASED (Type or print) LEVIN First JOHNSON Middle JAMES Last SOTHORON		4. DATE OF DEATH April 17 1957	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-28-1872
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if casually) Medical Doctor		10b. KIND OF BUSINESS OR INDUSTRY Medicine	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Levin S. Sothoron, Sr.		14. MOTHER'S MAIDEN NAME Lillian Cantor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT NORWOOD SOTHORON, Charlotte Hall, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Acute Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease DUE TO 3 YRS. (c) 4 DAYS		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Operation 3-25-59: Acute Intestinal Obstruction - Recurrent			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 10, 1958 , to April 19, 1959 , that I last saw the deceased alive on April 19, 1959 , and that death occurred at 7:10 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Warren Jarboe M.D.		DATE SIGNED Apr 19 1959	
PHYSICIAN'S NAME (Type) J. PARRIAN JARBOE, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 4-22-59	22c. NAME OF CEMETERY OR CREMATORY All Faith	22d. LOCATION (City, town, or county) (State) Charlotte Hall, Md.
23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md.		24a. REC'D BY REGISTRAR APR 24 '59	
		24b. REGISTRAR'S SIGNATURE Arthur L. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



04272

MEDICAL CERTIFICATION



4283

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X La Plata			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicans Memorial Hospital				/d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Gertrude Middle L. Last Welch				4. DATE OF DEATH Month April Day 10 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 11, 1894		9. AGE (in years last birthday) 64 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Charles County, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Garrett Ching				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Hydrick B. Welch - Pomfret, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis 170.7 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Malignant Melanoma of Left Leg DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 6 Mos. 2 YRS.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April, 1957 to April 10, 1959 , that I last saw the deceased alive on April 10, 1959 , and that death occurred at 7:40 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE J. PARRIAN JARBOE M.D.				ADDRESS (Street, city or town, state) La Plata, Md.		DATE SIGNED 4-11-59	
PHYSICIAN'S NAME (Type) J. PARRIAN JARBOE M.D.				La Plata, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/13/1959		22c. NAME OF CEMETERY OR CREMATORY Christ Church Cemetery		22d. LOCATION (City, town, or county) (State) Wayside, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE AREHART FUNERAL HOME, INC. * LA PLATA, MD.				24a. REC'D BY REGISTRAR APR 14 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04274

Reg. Dist. No.

4284

1. PLACE OF DEATH a. COUNTY Charles MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata			c. LENGTH OF STAY IN 1b 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Physicians Memorial Hospital						d. STREET ADDRESS 	
3. NAME OF DECEASED (Type or print) First JAMES Middle WARREN Last WILKINSON						4. DATE OF DEATH Month April Day 18 Year 19 59	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 	
9. AGE (In years last birthday) 35 yrs.				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) labored		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME George F. Wilkinson			
14. MOTHER'S MAIDEN NAME Mary Tippet				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes WWII			
16. SOCIAL SECURITY NO. 218-16-8871				17. INFORMANT Mrs. George F. Wilkinson, Waldorf, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon Monoxide Poisoning. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Extensive Burns. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Conflagration			
20c. TIME OF INJURY Hour XX p.m. 4/18 19 59		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Waldorf Charles Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE 				DATE SIGNED 4/20/59			
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4 21 59		22c. NAME OF CEMETERY OR CREMATORY St. Mary's		22d. LOCATION (City, town, or county) Aquasco, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE 				24a. REC'D BY REGISTRAR DATE APR 22 '59			
24b. REGISTRAR'S SIGNATURE 				 			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

4285

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf		c. LENGTH OF STAY IN 1b Unk		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First LEE		Middle L.		Last WOOD	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-24-1888	
9. AGE (In years last birthday) 70 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Wood				14. MOTHER'S MAIDEN NAME Cynthia Jane Parks			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 223-30-5237		17. INFORMANT Eugene Wood, Waldorf, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senile arteriosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-22 , 19 57 , to 7-29 , 19 57 , that I last saw the deceased alive on 7-29 , 19 57 , and that death occurred at 1:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Richard H. Dobson M.D.				SIGNATURE Brandywine, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/2/59		22c. NAME OF CEMETERY OR CREMATORY Oakland		22d. LOCATION (City, town, or county) (State) Waldorf, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Maryland				24a. REC'D BY REGISTRAR DATE MAY 5 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

VS A15
15M 9/2/04 (4)

CERTIFICATE OF DEATH

1958

DATE

LOCALITY

AGE

CAUSE OF DEATH

DATE

TIME

PLACE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF INTERMENT

PLACE OF INTERMENT

DATE OF BURIAL

PLACE OF BURIAL

DATE OF CREMATION

PLACE OF CREMATION

DATE OF DISPOSITION

PLACE OF DISPOSITION

DATE OF RECOVERY

PLACE OF RECOVERY

